Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:

BRECKENRIDGE SURGERY CENTER
3201 E. GEORGE BUSH FWY., STE. 100
RICHARDSON, TX 75082

MFDR Tracking #: M4-09-9344-01

Respondent Name and Box #:

ARCH INSURANCE CO.
Rep Box # 19

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Code doesn't bundle with other procedures."

Principal Documentation:

1. DWC 60 package
2. Total amount sought - $1,364.13
3. CMS 1500
4. EOB's
5. Operative Report

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: The Respondent did not submit a response to the request for medical dispute resolution.

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
3/25/09	25230-SG	97, W1, BL	1-4	$1,364.13
Total /Due:				$1,364.13

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective 08/31/08, set out the reimbursement guidelines.

1. The disputed services were denied or reduced reimbursement based upon:
   - "97-Payment is included in the allowance for another service/procedure;
   - W1-Workers Compensation Fee Schedule Adjustment;
   - 97 and W1-This line was included in the reconsideration of this previously reviewed bill;
   - BL-This bill is a reconsideration of a previously reviewed bill;
   - BL-Additional allowance is not recommended as this claim was paid in accordance with state guidelines, usual/customary policies, or the provider;
   - BL-To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a rec."
2. The 3/25/09 operative report indicates the claimant underwent the following:
   - "Proximal row carpectomy and radial styloidectomy."
3. On the disputed date of service the Requestor billed CPT codes 25215-SG and 25230-SG. The insurance carrier incorrectly denied reimbursement for CPT code 25230-SG based upon it be included with 25215-SG; therefore, reimbursement per Rule 134.402 is recommended.
4. Per Rule 134.402(f) reimbursement for non-device intensive procedure for CPT code 25230-SG is:

   The CY 2009 fully implemented ASC Relative Payment Weight for CPT code 25230-SG is 28.1246.
   The Medicare Conversion Factor is $41.393. Therefore, 28.1246 X $41.393 = $1,164.16.

   The national Medicare reimbursement is divided by 2 = $582.08 ($1,164.16/2).

   This number X City Conversion Factor/CMS Wage Index for Richardson $582.08X 0.9945 = $578.88.

   The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted half of the national reimbursement $582.08 + $578.88 = $1,160.96.

   Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $1,160.96 X 235% = $2,728.26.

   This number $2,728.26 multiplied by 50% for multiple procedure rule = $1,364.13.

   The MAR for CPT code 25230-SG is $1,364.13. The insurance carrier paid $0.00. The difference between amount due and paid equals $1,364.13, this amount is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §134.1
28 Texas Administrative Code §134.402 effective 08/31/08

PART VII: DIVISION ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of **$1,364.13** plus applicable accrued interest per Division Rule §134.130, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date
		8/20/09

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.